MDR: M4-02-4623-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305, titled Medical Dispute Resolution-General, and 133.307, titled Medical Dispute Resolution of a Medical Fee Dispute, a review was conducted by the Medical Review Division regarding a medical fee dispute between the requestor and the respondent named above.

I. DISPUTE

1. a. Whether there should be additional reimbursement for date of service 5-10-02.
   b. The request was received on 7-23-02.

II. EXHIBITS

1. Requestor, Exhibit I:
   a. TWCC 60
   b. HCFA
   c. TWCC 62s
   d. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.

2. Respondent, Exhibit II:
   a. TWCC 60
   b. HCFA
   c. TWCC 62s
   b. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.

3. Per Rule 133.307 (g) (4), the Division forwarded a copy of the requestor's additional documentation to the carrier on 9-16-02. The respondent did not respond to the additional documentation. It's initial response is reflected in Exhibit II.

4. Notice of A letter Requesting Additional Information, is reflected as Exhibit III of the Commission's case file.

III. PARTIES' POSITIONS

1. Requestor: Position statement taken from Table of Disputed Services:
   "We feel that we are due full and total reimbursement for the D.M.E. provided to this patient. We obtained Pre-Authorization per TWCC Rule 134.600 and there was no pre-negotiated amount for the purchase of this equipment. The Insurance Carrier has incorrectly viewed this claim. We are now requesting that the remaining balance be paid In Full [sic]."

2. Respondent: Position statement taken from TWCC 60:
   "Claim has been paid."

IV. FINDINGS

1. Based on Commission Rule 133.307(d) (1) (2), the only date of service eligible for review is 5-10-02.

2. The carrier denied the billed services as reflected on the EOBs as, "A – PREAUTHORIZATION REQUIRED BUT NOT OBTAINED; M – NO MAR, REDUCED TO FAIR AND REASONABLE; S – SUPPLEMENTAL PAYMENT RE-EVALUATION **ADDITIONAL RECOMMENDED ALLOWANCE**; H – HALF PAYMENT SUGGEST SUPPLY HOUSE INVOICE FOR ADDTL' RECOMMENDATION".

3. The following table identifies the disputed services and Medical Review Division's rationale:

DOS	CPT or Revenue CODE	BILLED	PAID	EOB	MAR$	REFERENCE	RATIONALE:
5-10-02	E1399	$40.00	$20.00	A,S,H	DOP	MFG: Durable Medical Equipment (DME) Ground Rules (IV); TWCC Rule 133.304 (c); HCPCS descriptor	The carrier initially denied the disputed code as "A". After reconsideration the carrier reimbursed the Provider $20.00 of the $40.00 charge and denied the code at that time as "S" and "H". The DME Ground Rules, (IV) states if the DME item does not contain a specific MAR, "The DME items should be billed at the usual and customary rate of the DME provider, and the insurance carrier shall reimburse the DME provider at an amount pre-negotiated between the provider and carrier or, if there is no pre-negotiated amount, the fair and reasonable rate for the item described. Use the miscellaneous HCPCS code, E1399, when no other HCPCS code is present for the DME or supplies provided to the injured worker." The carrier upon reaudit reimbursed the provider ½ of the billed amount and utilized the denial codes of "S" and "H". This payment voids the preauthorization denial. There is no MAR for the HCPCS code billed. TWCC Rule 133.304 (c) states, "The explanation of benefits shall include the correct payment exception codes required by the Commission's instructions, and shall provide sufficient explanation to allow the sender to understand the reason(s) for the insurance carrier's actions(s). A generic statement that simply states a conclusion such as "not sufficiently documented" or other similar phrases with no further description for the reason for the reduction or denial of payment does not satisfy the requirements of this section." The Carrier has failed to provide sufficient explanation of their denial as required by Rule 133.304 (c). Therefore, additional reimbursement is recommended in the amount of **$20.00**. (Billed $40.00 - $20.00 already paid = $20.00.)
5-10-02	E0748-NU	$5,000.00	$4160.00	S,M	DOP	MFG GI (VIII) (A); HCPCS descriptor	The "NU" modifier is not recognized in the Commission's '96 MFG. For this reason, MRD is unable to determine proper reimbursement for the DME in dispute. Therefore, **no** additional reimbursement is recommended.

Totals	$5,040.00	$4180.00		The Requestor **is** entitled to additional reimbursement in the amount of $20.00.

V. ORDER

Pursuant to Sections 402.042, 413.016, 413.031, and 413.019 the Medical Review Division hereby ORDERS the Respondent to remit $20.00 plus all accrued interest due at the time of payment to the Requestor within 20 days receipt of this order.

This Order is hereby issued this 28th day of March 2003.

Lesa Lenart
Medical Dispute Resolution Officer
Medical Review Division

LL/ll